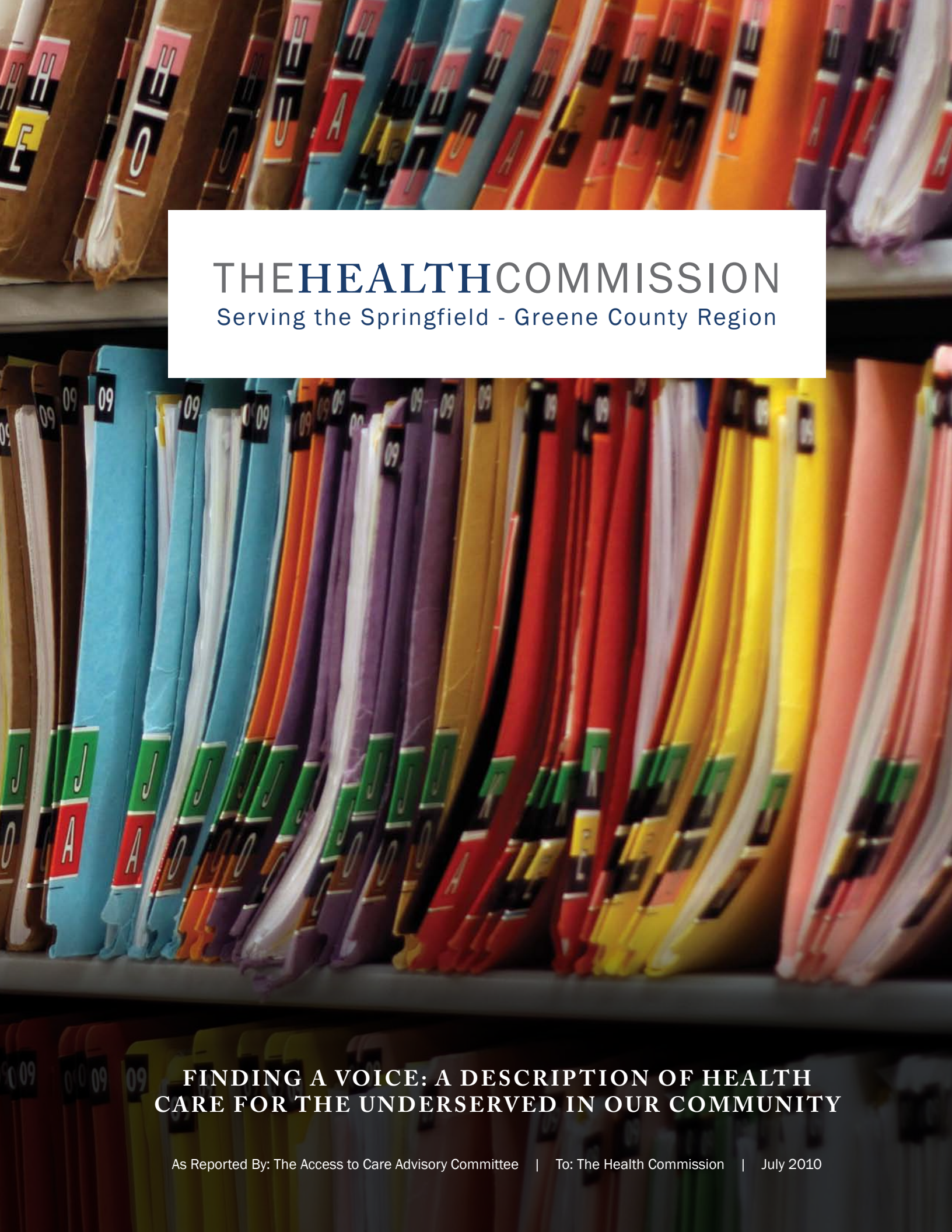

THE**HEALTH**COMMISSION

Serving the Springfield - Greene County Region

FINDING A VOICE: A DESCRIPTION OF HEALTH CARE FOR THE UNDERSERVED IN OUR COMMUNITY

As Reported By: The Access to Care Advisory Committee | To: The Health Commission | July 2010

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EXECUTIVE SUMMARY

WELCOME TO THE FIRST REPORT TO THE COMMUNITY FROM THE HEALTH COMMISSION. THE ACCESS TO CARE COMMITTEE (ACAC) HAS WORKED FOR 10 MONTHS TO BE THE EARS FOR THE PEOPLE IN OUR COMMUNITY. THE FOLLOWING REPORT ARTICULATES THE MANY CHALLENGES FACED BY OUR HEALTH CARE SYSTEMS, PROVIDERS, AND MOST IMPORTANTLY OUR FELLOW CITIZENS IN ACCESSING HEALTH CARE.

This report details many important findings and opportunities for community-based action and further investigation. The following list is meant to provide a high-level view to give a firm foundation as you read the report in greater detail.

» 75.0% of all Emergency Department (ED) visits for patients without insurance were by patients aged 20 to 49 in 2009, a slight increase from 2008. Further analysis reveals the vast majority of these visits relate to dental problems. This compares to 45.0% of all ED visits occurring in the 20 to 49 age group when all payer types are included, and 27.0% of all ED visits in the 20 to 49 age group for those covered by MO HealthNet (Medicaid).

» 60.0% of patients seeking primary care in Springfield reside outside Greene County. The number of primary care providers within the county is most likely inadequate to serve the needs of the Greene County citizens even without this external demand.

Greene County safety-net clinics provided health care to over 33,718 unduplicated patients in 2009. With Cox Family Medicine Residency Program, Family Medical Care Center (FMCC) seeing 8.0 % uninsured, 44.0% MO HealthNet (Medicaid); Jordan Valley Community Health Center (JVCHC) seeing 15.0% uninsured, 50.0% MO HealthNet (Medicaid); The Kitchen Clinic 100.0% uninsured, and Ozarks Community Hospital Medicaid clinics seeing 2.0% uninsured and 64.0% MO HealthNet (Medicaid). A reasonable estimate of uninsured patients in Greene County is up to 40,000.

Jordan Valley Community Health Center provides over 90.0% of the safety net dental services. These services are directed at children and consume all the capacity within Jordan Valley Community Health Center's dental operation.

Overall, patients are appreciative of the care they receive. They still perceive at times they are treated differently by health systems and safety net clinics, than those who have insurance.

Patients face many barriers to seeking out primary care including transportation, operating hours of clinics, limited willingness of non-safety net clinics to accept patients with no insurance or MO HealthNet (Medicaid), and limited access to safety-net clinics. This is especially true for patients with dental needs. Patients often turn to the ED despite knowing that, if they could overcome these barriers, the nature of most of their problems could have been treated in a primary care provider's or dentist's office.

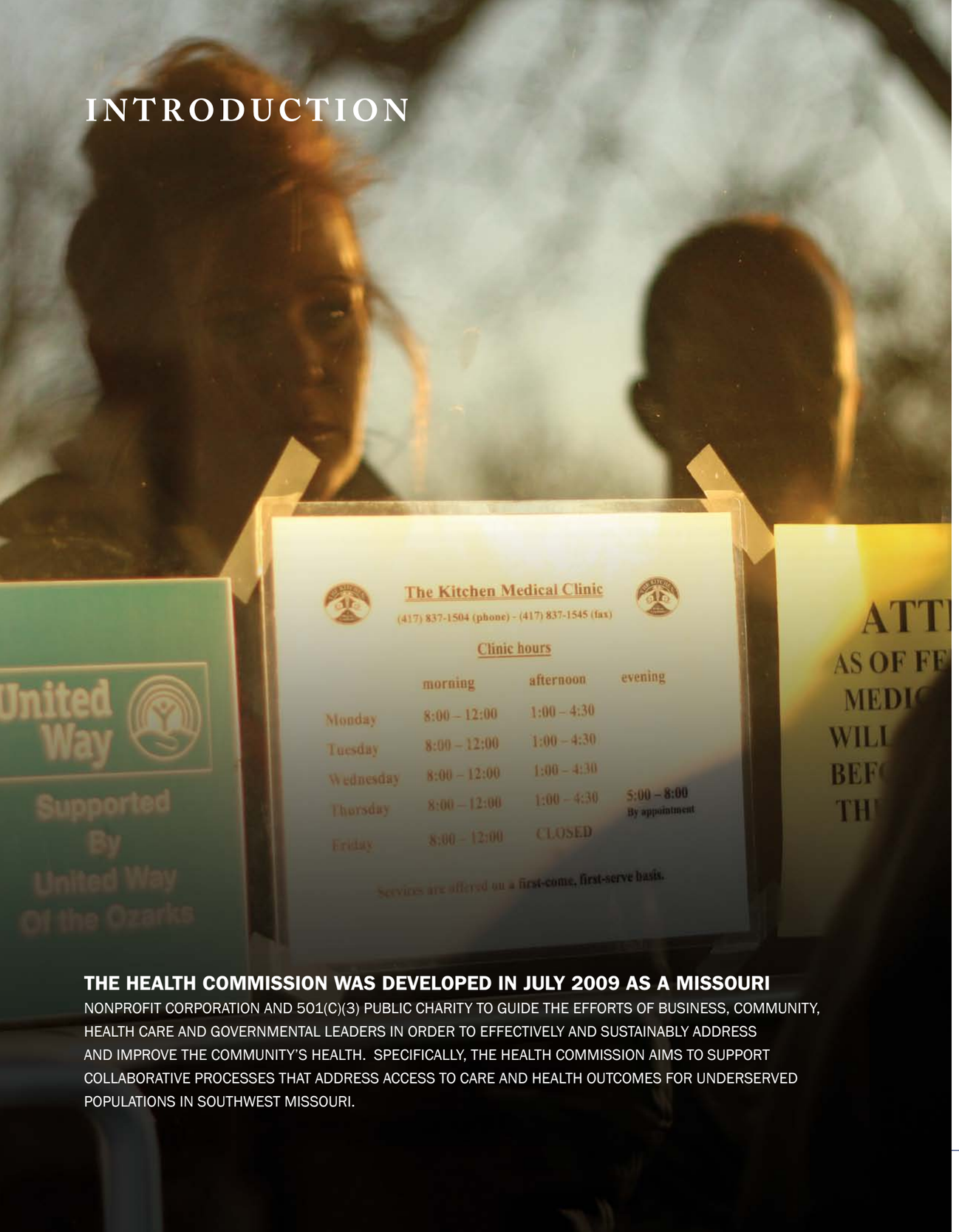
The ACAC believes The Health Commission needs to have a better understanding of our community in order to prioritize future efforts in an effective manner. The ACAC recommends that future community health assessments build off of this framework and include greater detail regarding the population, the health care system, the safety net and the patient.

This report represents the work of several talented and willing volunteers. Additionally, The Health Commission performed the work of coordinating, scheduling and focusing the group.

As you read through the following pages you will see a progression of viewing our community from the population down to the patients. We hope these views allow you to appreciate the complexity present for all those working to better the health of our community. In doing so, we ask you to embrace the challenges we face and work with us on a personal level to improve our community for all.

Dan Sontheimer, MD, MBA
Vice President and Chief Medical Officer

INTRODUCTION



THE HEALTH COMMISSION WAS DEVELOPED IN JULY 2009 AS A MISSOURI NONPROFIT CORPORATION AND 501(C)(3) PUBLIC CHARITY TO GUIDE THE EFFORTS OF BUSINESS, COMMUNITY, HEALTH CARE AND GOVERNMENTAL LEADERS IN ORDER TO EFFECTIVELY AND SUSTAINABLY ADDRESS AND IMPROVE THE COMMUNITY'S HEALTH. SPECIFICALLY, THE HEALTH COMMISSION AIMS TO SUPPORT COLLABORATIVE PROCESSES THAT ADDRESS ACCESS TO CARE AND HEALTH OUTCOMES FOR UNDERSERVED POPULATIONS IN SOUTHWEST MISSOURI.

The vision of The Health Commission is quality health care that is accessible and available for all people and sustainable for our community.

The mission of The Health Commission is to assist in building community partnerships that promote affordable quality health care for the underserved.

The Health Commission has developed and implemented a sophisticated process of community health assessment and planning for the region. This is the first report of its kind and its purpose is to identify health issues of primary concern and to provide critical information to those in a position to make an impact on the health of our region, for example governments, social service agencies, businesses, health care providers and consumers.

Our methodology in rendering a complete picture of the health of our community and region includes four key components: (1) quantitative data drawn from public health indicators; (2) quantitative data drawn from Emergency Department (ED) visits and outpatient primary medical care clinics, including capacity measures; (3) quantitative data drawn from safety-net clinics and primary medical, dental and behavioral health capacity measures; and (4) qualitative data drawn from uninsured and MO HealthNet (Medicaid) surveys and focus groups. The data collection, analysis and reporting process was managed by The Health Commission's staff and directed by the Access to Care Advisory Committee (ACAC), a 10 member committee with broad provider representation with regard to primary medical, dental and behavioral health care. Research efforts were contractually supported through Missouri State University and Bryles Research, Inc. From September 2009 through June 2010, members of the ACAC convened 25 times to provide guidance on the assessment.

The data collection and analysis includes four key components:

Public Health Indicators – The health of a community depends on many different factors, including the quality of health care, individual behavior, education and the socio-economic environment. Community health outcomes are measured in part by core public health and prevention indicators which determine whether communities address all health factors with effective, evidence-based programs. These public health indicators provide a basic overview of the community's socio-economic status and health status. Quantitative data was derived from the Springfield-Greene County Health Department, Missouri Department of Health and Senior Services and Centers for Disease Control.

Hospital and ED Indicators – Recognizing the importance of emergency medicine and trauma care in our community and acknowledging the critical problems patients face when these services are or are not readily available is vital to the community's health. EDs provide an essential community service and are vital to the community's health, caring for everyone, regardless of ability to pay or insurance status. By monitoring and measuring the number of ED visits, the primary diagnosis for each visit, the level of service for every ED visit and the type of health insurance of patients utilizing the ED, community health efforts may better direct efforts toward the accessibility of appropriate care and the message of prevention. The hospital and ED indicators determine utilization trends that may impact community health outcomes. Quantitative data was derived from the Missouri Hospital Association and Greene County hospitals.

Safety-Net Indicators – Health care safety-net clinics are those that have a mission to offer medical care to all patients, regardless of their ability to pay, and have a substantial number of patients who are uninsured or on MO HealthNet (Medicaid). By monitoring and measuring the number of visits, the capacity, the scale and scope of services, and the coordination of services, community health efforts can be directed in a manner that meets the underserved population's needs in a sustainable manner. The safety-net indicators determine utilization and capacity trends that impact the community's – and in particular, the underserved's – health. Quantitative data was derived from the Family Medical Care Center, Jordan Valley Community Health Center, Ozarks Community Hospital's Medicaid Clinic, and The Kitchen Clinic, and complemented by insights of safety-net clinicians with their "boots on the ground."

Patient Indicators – Community health perceptions are important to consider when evaluating the community's health and the overall delivery of health care. In particular, allowing the community to identify accessibility, availability and affordability issues allows communities to better recognize opportunities for improvement and innovative solutions. Qualitative data was derived from 540 individuals through a community-wide health survey filtered through area EDs and safety-net clinics, and through six homogenous focus groups.

In keeping with The Health Commission's mission to assist in building community partnerships that promote affordable quality health care for the underserved, the methodology used brought together hospitals, public health and other community health partners to develop the ACAC. This 10 member committee completed in full the report that follows.

The results enable us to more strategically establish priorities, develop interventions and commit resources to improve the health of our communities and region. To review the report in full with all data references, please visit The Health Commission's website at:

www.thehealthcommission.org.

THE POPULATION

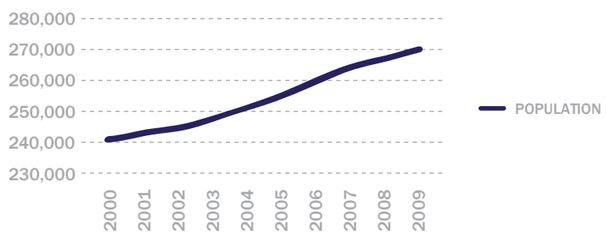
The following indicators have been analyzed for Greene County to identify potential trends in health outcomes in our community. The state of the community's health consists of more than the mere absence or presence of disease. According to the World Health Organization (WHO), the social determinants of health are the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices. The social determinants of health are mostly responsible for health inequities – the unfair and avoidable differences in health status seen within and between different populations. There is a direct correlation between public health outcomes and the social determinants of health. Thus, this report wishes to emphasize that the health and well-being of a community cannot be overcome by solely focusing on increasing access to health care.

Because this report is primarily focused on access to care for the underserved, certain core public health focus areas related to maternal and child health are not included. In an attempt to provide a broad overview of these indicators, it should be noted that Greene County has done a good job in providing pregnant women access to prenatal care. Nearly 50.0% of all pregnancies in Greene County are enrolled in MO HealthNet (Medicaid). Pregnant women who are enrolled in MO HealthNet (Medicaid) are eligible to receive Women, Infants and Children (WIC) program services; however, only 44.0% of those enrolled take advantage of these services. Of great concern, nearly 20.0% of mothers smoke during pregnancy, which is higher than the United States average of 14.0%.

POPULATION

In 2009, approximately 269,630 people were living in Greene County. From 2000 to 2009 the population growth was 12.2% as compared to 9.1% for the United States as a whole. The area's population growth is projected to remain above the United States average. The median average age has remained around 35, which is approximately two years younger than the United States average. Approximately 22.0% of the population was under the age of 18, 64.0% between the ages of 18 and 64, and 14.0% over the age of 65. Approximately 52.1% of the population was female and 47.9% male. Residents in the age group of 18 to 64 represent the vast majority of underserved patients both nationally and locally.

GREENE COUNTY POPULATION
from 2000 to 2009



THE SOCIAL DETERMINANTS OF HEALTH ARE MOSTLY
RESPONSIBLE FOR HEALTH INEQUITIES – THE UNFAIR AND AVOIDABLE DIFFERENCES IN HEALTH STATUS SEEN WITHIN AND BETWEEN DIFFERENT POPULATIONS.

ETHNICITY AND RACE

As the area has grown, there has been an increase in racial and ethnic diversity. African American death rates tend to be higher than those found in Caucasian counterparts. In particular, those related to chronic diseases tend to be significantly higher. African Americans also appear to access health care through ED settings at a higher rate than Caucasian counterparts. Outcome data for other ethnic groups is currently unavailable.

RACE & ETHNICITY COMPARISONS

Race or Ethnicity	Greene County	Missouri	United States
White or Caucasian	92.5%	83.9%	74.3%
Hispanic or Latino	2.7%	3.2%	15.1%
Black or African American	2.6%	11.2%	12.3%
Asian or Pacific Islander	1.4%	1.5%	4.5%
American Indian	0.3%	0.4%	0.8%
Two or More Races	2.2%	2.0%	2.2%

CHRONIC DISEASE

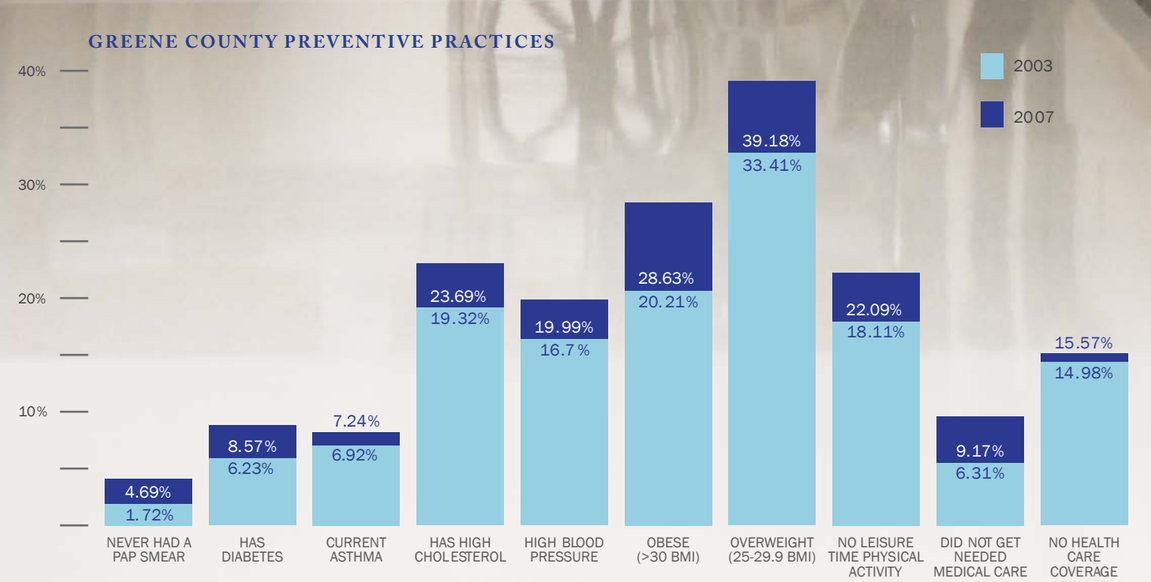
Chronic diseases are among the most costly, prevalent and preventable of all health problems. Access to affordable and high-quality prevention measures (including screening and appropriate follow-up care) are essential steps in lowering the costs for medical care, reducing the rates of chronic disease and saving lives.

A significant percentage of the population suffers from any one of a number of chronic conditions, and many people suffer from multiple chronic conditions. Many of these diseases may not have warning signs noticeable by a patient. Other times, warning signs may be ignored, resulting in long-term consequences.

Because data about the cause of death is more readily available, it is often used as a marker of the impact of chronic disease. The top five chronic diseases in Greene County correspond with those for the United States. It should be noted that in the chronic lower respiratory disease state, Greene County has a high incidence of lung disease with a rate of 79.5 when compared to the average rate of 71.3 in the United States. The two highest death rates stem from heart disease and cancer, which coincide with the area's high overweight and obesity rates, tobacco use and poor preventive practices.

5 MOST COMMON CAUSES OF DEATH (RATE PER 100,000 POPULATION)

Chronic Disease	Greene County	Missouri	United States
Heart Disease	202.5	235.5	211.1
All Cancers	176.5	197.7	183.8
Chronic Lower Respiratory Diseases	57.7	49.2	43.2
Unintentional Injuries	43.6	47.4	39.1
Stroke	42.0	52.6	46.6



HEALTH AND PREVENTIVE PRACTICES

In 2007, a Missouri county-level study revealed the health and preventive practices of Greene County citizens to determine overall health status when compared to the United States. As indicated below, general preventive practices are slowly decreasing in Greene County.

POVERTY AND UNEMPLOYMENT RATES

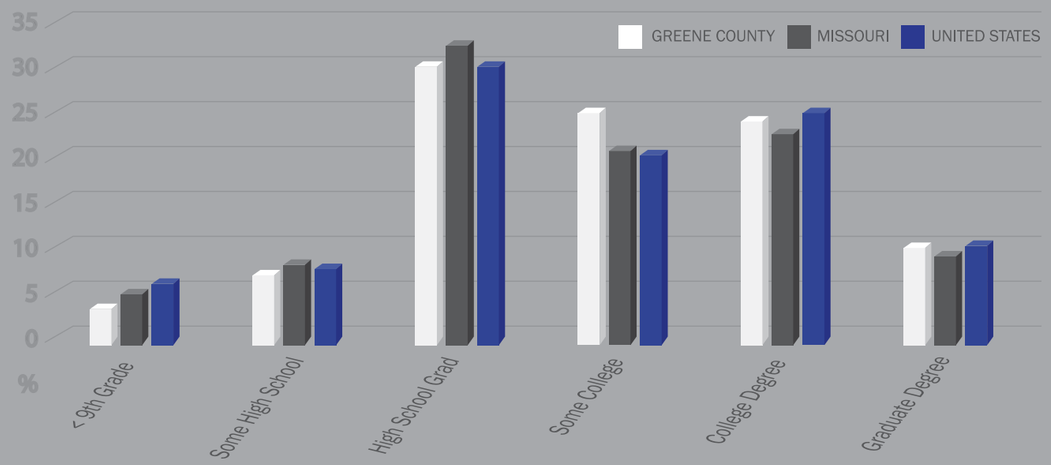
IN 2008, GREENE COUNTY HAD 15.9% OF THE POPULATION LIVING AT OR BELOW POVERTY LEVEL. THIS RATE EXCEEDS THE AVERAGE POVERTY RATE OF 13.4% FOR MISSOURI AND 12.7% FOR THE UNITED STATES. APPROXIMATELY 11.5% OF ALL FAMILIES AND 35.6% OF ALL SINGLE FAMILIES WITH A FEMALE HOUSEHOLDER LIVED AT OR BELOW THE POVERTY LEVEL AND NEARLY 19.3% OF CHILDREN UNDER THE AGES OF 18 LIVED AT POVERTY, WHICH ALSO EXCEEDS THE STATE AND NATIONAL AVERAGES. IN 2009, THE AVERAGE UNEMPLOYMENT RATE WAS 9.5%, WHICH FELL CLOSELY TO THE NATIONAL UNEMPLOYMENT RATE OF 9.4%. THE RELATIONSHIPS BETWEEN SOCIO-ECONOMIC STATUS AND HEALTH STATUS ARE WELL ESTABLISHED AND IMPACT ACCESS TO CARE.

The area faces growing concerns regarding the falling average wage rate and per capita income level. Unfortunately, the region's average wage rate and per capita income level continue to fall below comparison cities. While this category has shown growth, Greene County still lags behind on per capita income, even after adjusting for cost of living differences. Moreover, poverty plays a significant role in pediatric health outcomes. Based on growing estimates from the Office of Social and Economic Analysis (OSEDA) and the increasing demand at food banks and school systems' free and reduced school lunch plans, attention is growing on poverty rates and related health outcomes for those under the age of 18.

Educational attainment in Greene County is higher on average than in Missouri as a whole. The reported highest educational attainment of residents in their twenties is higher than the United States average. Despite good levels of educational attainment, Greene County residents still struggle with a poor wage index magnifying socio-economic problems and related health outcomes.

As evidenced by Kaiser's Commission on Medicaid and the uninsured, those with lower economic status often have reduced access to health insurance, less information from health care providers, reduced ability to pay for medical care, reduced ability to pay for healthy lifestyles and reduced access to transportation needed to access health care services.

2009 HIGHEST EDUCATION ATTAINMENT



SUMMARY OF CONCLUSIONS

WHEN COMPARED TO ALL COUNTIES IN MISSOURI, GREENE COUNTY RANKS 29 OUT OF 115 COUNTIES IN TERMS OF HEALTH OUTCOMES AND 10 OUT OF 115 IN TERMS OF HEALTH FACTORS. HEALTH OUTCOMES RANKING IS BASED ON MEASURES OF MORTALITY AND MORBIDITY. THE MORTALITY RANK, REPRESENTING LENGTH OF LIFE, IS BASED ON A MEASURE OF PREMATURE DEATH, WHICH IS DEFINED AS THE YEARS OF POTENTIAL LIFE LOST PRIOR TO THE AGE OF 75. THE MORBIDITY RANK IS BASED ON MEASURES THAT REPRESENT HEALTH-RELATED QUALITY OF LIFE AND BIRTH OUTCOMES. IN THIS MEASURE FOUR MORBIDITY MEASURES ARE INCLUDED: SELF-REPORTED FAIR OR POOR HEALTH, POOR PHYSICAL HEALTH DAYS, POOR MENTAL HEALTH DAYS AND THE PERCENT OF BIRTHS WITH LOW BIRTH WEIGHT. GREENE COUNTY'S MORTALITY RATE IS 26 OUT OF 115; THE MORBIDITY RATE IS 37 OUT OF 115.

The general health status of our population is good. Our community compares well with the state as a whole; however, our state compares poorly to the rest of the United States.

The population is increasing at a higher than average rate and growing more diverse. The increase in minority populations increases the risk of unfavorable health status disparities.

Deaths associated with chronic disease are higher than the average rates in Missouri and the United States and are associated with the poor rates of preventive practices.

There are a growing number of residents living in poverty, which directly affects both residents' access to health care and health outcomes.

29 OF 115 FOR HEALTH OUTCOMES

10 OF 115 FOR HEALTH FACTORS

26 OF 115 FOR MORTALITY RATE

37 OF 115 FOR MORBIDITY RATE

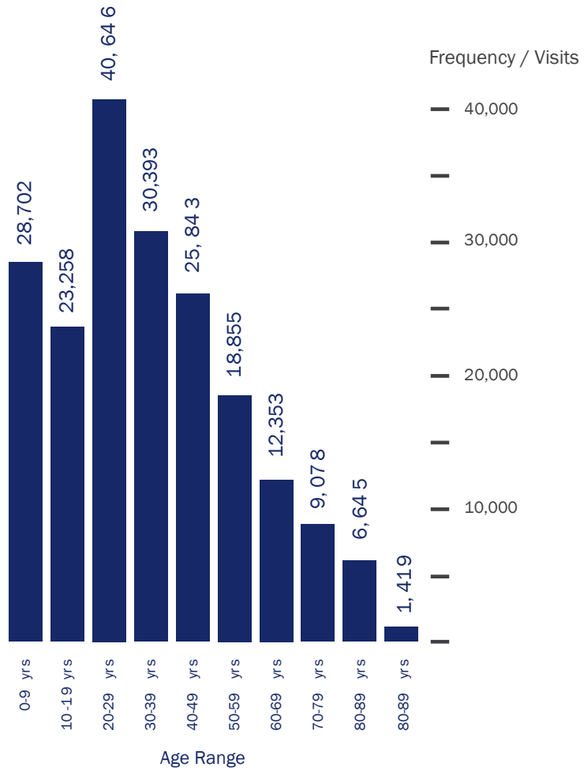
THE HEALTH CARE SYSTEM

OVERVIEW OF GREENE COUNTY ED ENCOUNTERS

In 2009, there were a total of 197,228 ED visits in Greene County hospitals. Only 19.9% of the visits were by uninsured or self-pay individuals and 26.1% were by individuals with MO HealthNet (Medicaid) insurance. The remaining 54.0% of all visits were by individuals who were either privately insured or had Medicare insurance. This signifies that people from all payer categories seek care within an ED and that the increased ED visits are not solely due to an increase in the number of uninsured individuals.

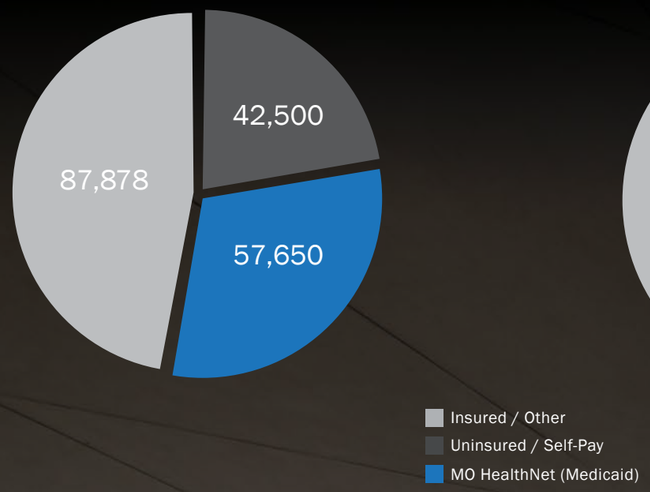
Of the total ED visits in 2009, three age ranges stand out as the predominant users of the EDs. Individuals aged 20 to 29 comprised 21.0% of all visits, individuals aged 30 to 39 comprised 15.4% of all visits and individuals from infancy to age nine comprised 13.1% of all visits. Almost half of all visits were from individuals ranging from 20 to 39 years of age. Interestingly, this follows the national trend of ED utilization by individuals and a partial explanation is that many in this age group are less likely to practice preventive measures and are more likely to seek care when their conditions demand services through an ED setting. Another factor in this age group may be the convenience of afterhours care in an ED setting, as compared to traditional clinic office hours. Finally, it is common for young children to represent a relatively high percentage of ED usage as seen in the chart below.

2009 GREENE COUNTY ED ENCOUNTERS BY AGE RANGE

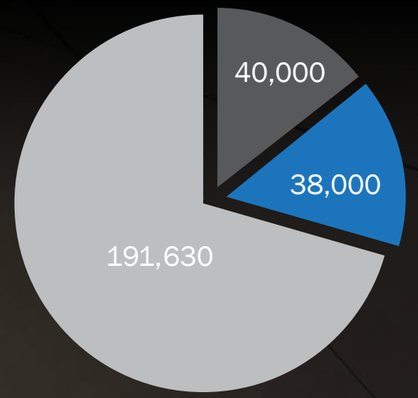


ACCORDING TO THE INSTITUTE FOR HEALTHCARE IMPROVEMENT,
ED VISITS HAVE BEEN STEADILY RISING IN THE UNITED STATES, INCREASING OVER THE PAST DECADE BY NEARLY 20.0%. DESPITE COMMONLY HELD ASSUMPTIONS, THIS IS NOT PRIMARILY DRIVEN BY INDIVIDUALS WHO ARE UNINSURED OR THOSE WITHOUT ACCESS TO A PRIMARY CARE PROVIDER. IN FACT, RESEARCH HAS REVEALED THAT ED USAGE HAS BEEN HIGH OVER ALL PAYER CATEGORIES AND INCLUDES A SIGNIFICANT NUMBER OF PATIENTS WHO ARE INSURED OR HAVE A PRIMARY CARE PROVIDER.

2009 ED PAYER MIX



2009 GREENE COUNTY POPULATION



Many trends are apparent when reviewing the use of EDs in 2009. The Health Commission believes it is important to understand whether these trends reflect appropriate or inappropriate ED utilization. Appropriate ED usage is defined by conditions that are acute in onset or severe in nature such as trauma, abrupt onset illness a patient has never experienced before, an acute complication of a chronic condition, etc. Inappropriate ED usage is represented by the treatment of self-limited acute minor conditions, suitable for treatment in less resource-intense environments outside the ED. One gauge of appropriateness is the level of service coded by attending physicians. Specifically, when visiting an ED, there are five levels to indicate the severity of the illness and resources used for treatment, with levels 1 and 2 representing acute, self-limited problems, which require resources readily available in a physician's office. Examples of conditions within these service levels are: insect bite, localized skin rash, lesion, sunburn, eye discharge, ear pain, urinary frequency without fever, and simple trauma.

The level of service coding approach is an attempt to reconcile the diagnosis treated and the level of resources required to treat the condition. Limiting our analysis to the top three conditions for each range and those requiring the lowest level of services allows the commission to generate inferences about which conditions treated in the ED may be candidates for treatment elsewhere. One limit of this approach is coding practices are not always uniform. One facility may assign a higher code for a given condition, while another assigns a lower code. Additionally, another limitation is the data reviewed do not give any indication as to what time of day or day of the week a service was used. For certain conditions, it may not be reasonable for a patient to wait over a weekend for lower acuity services to be used. Despite these limitations, the definitions used will remain stable for some time and through cooperative efforts of The Health Commission may become an opportunity for greater reliability in level of service coding assignments.

For the uninsured, MO HealthNet (Medicaid) and insured patients ages 20 to 39, dental pain was the primary purpose for seeking care in the ED. In fact, dental pain represented 7.3% of all ED visits, 10.2% of all MO HealthNet (Medicaid) visits and 37.3% of all uninsured visits, when limiting the analysis to the top three most common conditions for ED use by patients. Of the uninsured visits, 93.0% were at the 1 and 2 level of service for patients with a dental condition in age range of 20 to 39 years. Thus, only 7.0% of these visits by uninsured patients used resources unique to the ED environment. This translates to over 900 visits yearly suitable for treatment outside the ED.

For adults ages 30 to 49, the primary purpose for seeking care in the ED was related to bodily or back pain. For adults aged 50 and above, chest pain and respiratory issues were the primary reasons for seeking care in the ED.

THE CURRENT PRIMARY CARE WORKFORCE ACROSS ALL HEALTH SYSTEMS AND INCLUDING INDEPENDENTS CONSISTS OF 79 FAMILY PHYSICIANS, 76 GENERAL INTERNISTS, AND 33 PEDIATRICIANS.

Obstetrician-gynecologists were excluded in the primary care workforce due to difficulties in accounting for patients for whom they provide primary care versus those for whom they provide consultative care. Physician Assistants and Nurse Practitioners were counted as part of Greene County's total primary care provider capacity. Population estimates allow for prediction of how many patients will need to see a primary care provider on a given day (faster scheduling and more same-day appointments are making for happier patients—and busier practices, Walpert, B.; ACP-ASIM Observer, October, 1999).

While there are number of complex variables, a generally applicable rule is that from 0.7% to 1.0% of the population needs to see a primary care physician on a given day. Using this rule, there are 3,994 appointments open for primary care on a given day in Greene County. With 60.0% of primary care appointments being used by patients outside Greene County, then only 1,380 appointments are available for Greene County residents. This is against a forecasted demand ranging from 1,869 to 2,669 appointments needed for Greene County residents on a given day. Thus, there is a shortage of primary care access in the neighborhood of almost 500 to 1,000 appointments per day for Greene County residents alone. If the same ratio of Greene County to non-Greene county visits continues, then an additional 70 to 100 primary care providers may be needed to cover the patients accessing primary care in Greene County. This analysis is limited by the use of statistical demand models, with opportunity for further refinement.

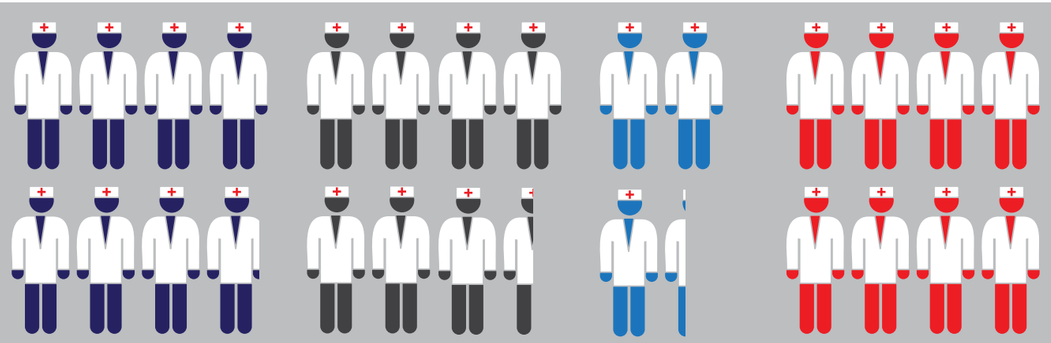
Another method for capacity determination is measuring the number of providers per population. The Council on Graduate Medical Education developed a method for ideal provider staffing based on population in its eighth report, Patient Care Physician Supply and Requirements. They concluded a need for 60-80 generalist providers per 100,000 residents. For Greene County, the 188 generalist primary care providers (this number includes Nurse Practitioners and Physician Assistants working in primary care) fall short of 216 providers needed on a strict population basis. This is without considering the rate of use of primary care services in Greene County by non-Greene county residents.

79 family physicians

76 general internists

33 pediatricians

70-100 primary care providers still needed



each icon represents 10 primary care providers

SUMMARY OF CONCLUSIONS

THERE ARE INSUFFICIENT NUMBERS OF PRIMARY CARE PHYSICIANS AND ASSOCIATED PROVIDERS FOR PATIENTS ACCESSING HEALTH CARE WITHIN GREENE COUNTY. IF ONLY THE CITIZENS OF GREENE COUNTY SOUGHT CARE FROM PROVIDERS WITHIN GREENE COUNTY, THEN THE CURRENT ALLOCATION OF PRIMARY CARE PROVIDERS STILL REMAINS INADEQUATE.

Analysis of codes from the ED data reveals a skewed distribution towards the lower level of codes (1 and 2). This may represent an educational opportunity to inform the community about conditions that need emergent care. It may also present a need for greater support and staffing of urgent care type facilities by health systems and clinics to provide access to acute care for self-limited conditions for patients regardless of insurance status.

The total ED visits (baseline use) for uninsured is 39,364, for Medicaid is 51,558, and for insured is 106,306.

The condition associated with the greatest level of ED use for both uninsured and MO HealthNet (Medicaid) patients is dental disorders.

75.0% of all visits for patients without insurance were by patients aged 20 to 49 in 2009, a slight increase from 2008. This compares to 45.0% of all ER visits occurring in the 20 to 49 age group when all payer types are included, and 27.0% of all ER visits in the 20 to 49 age group for those covered by MO HealthNet (Medicaid).

75% OF ALL VISITS: UNINSURED AGES 20 TO 49

45% OF ALL ER VISITS: ALL PAYER TYPES AGES 20 TO 49

27% OF ALL ER VISITS: MO HEALTHNET (MEDICAID) AGES 20 TO 49

THE SAFETY NET

The Institute of Medicine (IOM) defines the safety net in the United States as, “Those providers that organize and deliver a significant level of health care and other health-related services to uninsured, Medicaid, and other vulnerable patients.” Thus, core safety-net providers tend to have two distinguishing characteristics. First, the providers practice by a legal mandate or explicitly adopt a mission that they maintain an “open door policy,” offering access to services to patients regardless of their ability to pay. Second, a substantial share of the providers’ medical care is directed toward the uninsured, Medicaid, and other vulnerable patients.

Many accept the theory that the safety net serves a population that cannot readily enter mainstream medical care. Because of this, safety-net clinics have been developed to offer alternative ways for patients to access the health care system. Although the provision of health care services to this patient population is equally as important to those populations that are privately insured, many safety-net providers operate under precarious financial situations. These economic realities often drive the capacity of services available as detailed by this section of the report.

Theoretically, the safety net can be a medical home for the patients it serves, providing comprehensive primary medical care and coordinating other health care services such as dental and behavioral health care services. Within the current safety net system, two sets of barriers have been identified which challenge this model: barriers to access for patients and barriers to efficiencies for providers.

Access to safety net services is limited by social barriers faced by their patient population. A few examples of these barriers include transportation, lack of awareness of available services, and the initial cost of care to the patient.

System coordination problems exist between safety-net clinics and mainstream medical systems, which reduce the efficiency of safety-net providers. These include difficulties with referring patients between systems and with the sharing of patient health information. Further, underserved patients are more likely to have multiple socio-economic problems in addition to their health problems which take time and resources to address.

ALTHOUGH THE PROVISION OF HEALTH CARE SERVICES TO THIS PATIENT POPULATION IS EQUALLY AS IMPORTANT TO THOSE POPULATIONS THAT ARE PRIVATELY INSURED, MANY SAFETY-NET PROVIDERS OPERATE UNDER PRECARIOUS FINANCIAL SITUATIONS.

PRIMARY MEDICAL CARE

In Greene County, the medical safety-net is made up of a small, informal patchwork of institutions each with its own separate funding sources, services, and mission. The local system is primarily comprised of four clinics all located in the northern part of Springfield, in addition to local EDs. Access to these clinics occurs by clinic appointment or on a limited walk-in basis. The clinics also receive many referrals as follow up from ED visits and hospital discharges for patients without insurance or on MO HealthNet (Medicaid).

FAMILY MEDICAL CARE CENTER is a part of a local tertiary care medical system and is primarily a clinic for a Family Medicine Residency training program. It provides open door access to individuals and families covered by MO HealthNet (Medicaid).

JORDAN VALLEY COMMUNITY HEALTH CENTER is a Federally Qualified Health Center (FQHC) serving a large portion of individuals and families covered by MO HealthNet (Medicaid). It also provides a reduced cost of care to uninsured patients below 200.0% of the FPL on a sliding scale basis.

THE KITCHEN CLINIC is part of a charitable organization that receives funding from local benefactors and grants. It provides free clinical care to uninsured individuals and families at or below 133.0% of the FPL.

OZARKS COMMUNITY HOSPITAL MEDICAID CLINIC are part of another local medical center and provide open door access to individuals and families covered by MO HealthNet (Medicaid).

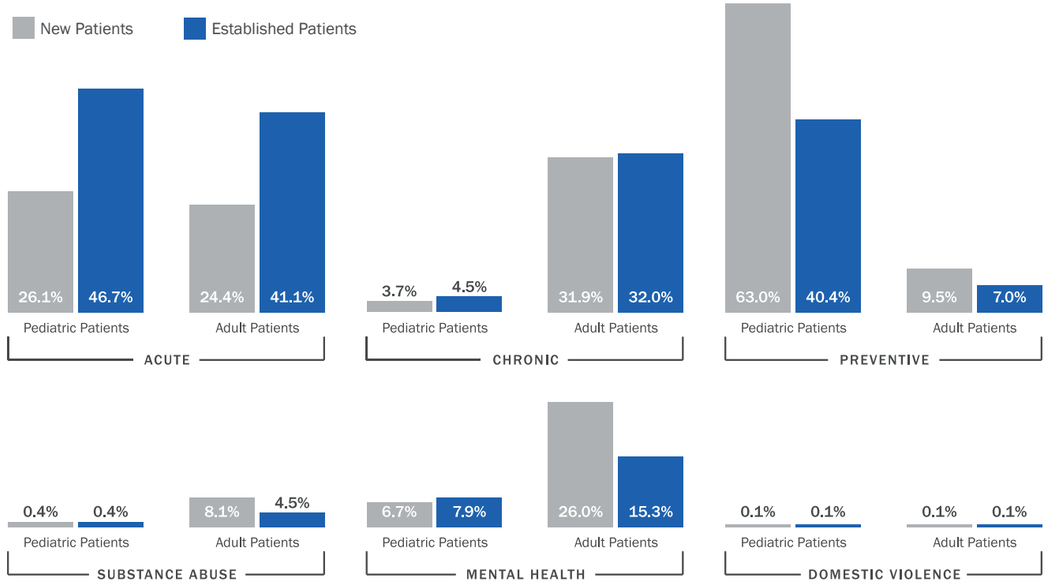
In 2009, there were 107,758 primary medical care visits to local safety-net clinics, an 11.4% increase from 2008.

SAFETY NET PRIMARY MEDICAL CARE DATA

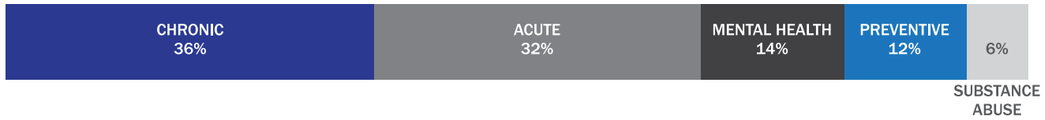
Safety Net Clinic	Total Visits	Unduplicated	Payer Mix	Total Provider FTEs
Family Medical Care Center	26,697	15,175	8.3% Self-Pay/Uninsured 43.5% Medicaid 20.7% Medicare 27.4% Commercial Insurance	13.8
Jordan Valley Community Health Center	41,092	16,421	30.6% Self-Pay/Uninsured 43.5% Medicaid 10.0% Medicare 15.9% Commercial Insurance	12.0
The Kitchen Clinic	6,476	2,122	100% Self-Pay/Uninsured 0% Medicaid 0% Medicare 0% Commercial Insurance	2.0
Ozarks Community Hospital Medicaid Clinic	33,493	unavailable	2.0% Self-Pay/Uninsured 64.0% Medicaid 23.0% Medicare 11.0% Commercial Insurance	9.0

We see below that an established patient with an acute care need is much more likely than a new patient to seek care in the safety net. This is true for both adult and pediatric patients. If the safety net is not utilized, the ED becomes the default method of health care. This reinforces the idea that not having an established medical home is crucial for decreasing "inappropriate" use of the ED.

PRIMARY MEDICAL CARE SERVICES BY PRIMARY DIAGNOSIS: NEW VERSUS ESTABLISHED PATIENTS 2009 (JVCHC AND FMCC)



PRIMARY REASON FOR SAFETY-NET CLINIC VISITS (JVCHC AND FMCC DATA)



Safety-net capacity is defined as the ability of the safety-net clinics to supply the number of providers and amount of space needed to meet the demands of the public. Using standard industry parameters in an average primary care practice, it is anticipated that a full-time primary care provider will see approximately 4,200 patients per year. There are approximately 37.0 full-time primary care providers in the safety-net. Given that number of providers, the safety net could manage approximately 47,000 additional visits per year under optimal provider conditions.

There is also a limit to capacity based on physical space. Recognizing that fact, there are a total of 164 exam rooms within the safety net. Based on three exam rooms per primary care provider, our current safety-net clinics could house approximately 55 providers (18 more than the 37 providers now serving the safety-net clinics). These additional 18 providers could potentially deliver about 75,000 additional visits under optional conditions.

PRIMARY DENTAL CARE

In Greene County, a large majority of the dental safety-net services are provided through three safety-net providers.

Jordan Valley Community Health Center is a Federally Qualified Health Center (FQHC) serving a large portion of individuals and families covered by MO HealthNet (Medicaid). It also provides a reduced cost of care to uninsured individuals at or below 200.0% of the FPL on a sliding scale basis.

The Kitchen Clinic is part of a charitable organization that receives funding from local benefactors and grants. It provides free clinical care to uninsured individuals and families at or below 133.0% of the FPL.

Ronald McDonald Care Mobile and the Tooth Truck are part of the Ronald McDonald House Charities and provide dental services to children at Springfield Public Schools through a mobile dental units.

In 2009, there were 33,677 dental visits between the dental clinic at Jordan Valley Community Health Center, the dental clinic at The Kitchen Clinic and the Ronald McDonald dental services. As can be seen in the data, access to dental health care services is severely limited for adults. Emergency pediatric appointments are available. Non-emergency pediatric appointments are available, but may have a waiting period of approximately two to three months.

A dental home offers an on going relationship between the dental provider and the patient, inclusive of all aspects of dental health care delivered in a comprehensive, continually accessible, coordinated, and family-centered way. It is recommended that a dental home be established no later than 12 months of age. Dental homes exist in our community for underserved pediatric patients, but not for underserved adult patients.

A large majority of safety-net dental services are provided through the dental clinic at Jordan Valley Community Health Center. The clinic places an emphasis on providing a dental home (comprehensive dental care including: restorative, preventive education, and regular follow-up appointments) for pediatric patients and pregnant women with MO HealthNet (Medicaid) insurance. The wait time between appointments is approximately one month. The wait time for a new patient is approximately two to three months.

SAFETY NET PRIMARY DENTAL CARE DATA

Safety Net Clinic	Total Visits	Unduplicated	Payer Mix	Total Provider FTEs
Jordan Valley Community Health Center	27,595	11,522	6.35% Self-Pay/Uninsured 89.6% Medicaid 0.0% Medicare 4.05% Commercial Insurance	11.4
The Kitchen Clinic	326	326	100% Self-Pay/Uninsured 0% Medicaid 0% Medicare 0% Commercial Insurance	0.1
Ronald McDonald Care Mobile & Tooth Truck	3,323	unavailable	unavailable	unavailable

MO HealthNet (Medicaid) does not provide any form of dental health coverage for most individuals over the age of 18. Therefore uninsured and MO HealthNet (Medicaid) adult emergency dental services are limited within the safety net. A small urgent care dental clinic has been established at Jordan Valley Community Health Center to provide reduced fee emergency dental services. The Kitchen Clinic also provides free dental care on an appointment basis. A final resource, called "Care to Give," is available through Jordan Valley Community Health Center as funding is available. On these days, Jordan Valley Community Health Center provides free pain management services, mostly extractions, to uninsured adults that have received a referral through a safety-net provider. An attempt is being made to better coordinate these days among the safety-net providers to provide services to those in greatest need. Because of this lack of availability and the inconsistency of services, these three resources have little impact on the reduction of frequency of Emergency Department dental encounters for the adult age group.

EDs do not have the ability to treat dental health care needs. Therefore, adults without dental insurance and MO HealthNet (Medicaid) adult patients have three options in seeking dental health care services. First, uninsured patients can get on the waiting list at the Kitchen Clinic if eligible. Second, they can pay an out-of-pocket reduced fee for emergency services at the urgent care dental clinic at Jordan Valley Community Health Center. Third, they can visit a private dentist who takes individuals not privately insured who must pay out of pocket. Since there is not an out of pocket cost when utilizing the hospital ED, the second and third options are nearly always dismissed by underserved adult patients.

There are approximately 11.5 full-time dentists providing care throughout the safety net. According to standard definitions, both Jordan Valley Community Health Center and the Ronald McDonald Care Mobile are operating at capacity. The primary limiting factor at the dental clinic within Jordan Valley Community Health Center is physical space and recruitment of dentists. The capacity of The Kitchen Clinic is limited by availability of volunteer dentists. It is difficult to determine the total number of patients that could be managed if the safety net were operating at optimal capacity, due to the variations in age and severity of conditions seen. However, for every additional dental care provider, the safety-net could manage approximately 3,000 more patients visits annually.

DENTAL VISITS IN SAFETY NET 2009

JVCHC DENTAL CLINIC

22,600 — 0 - 18 YEARS

6,922 — 19+ YEARS

KITCHEN CLINIC DENTAL

0 — 0 - 18 YEARS

326 — 19+ YEARS

RONALD MCDONALD CARE MOBILE

3,323 — 0 - 18 YEARS

0 — 19+ YEARS

PRIMARY BEHAVIORAL HEALTH CARE

It is widely understood that underserved patients experience higher rates of mental health problems than the general population. In area safety-net clinics, there is very limited on-site access to behavioral health care services, although integrated medical and behavioral care models have been shown to be effective in underserved populations.

The behavioral health care system provided in the Springfield-Greene County region is difficult to identify in its entirety, as there is no comprehensive listing of behavioral health providers and the services they offer. In order to gain some understanding of these local services, the ACAC conducted a public meeting, inviting area behavioral health providers to discuss their services and their challenges in providing care. We believe the meeting was successful in accurately representing local behavioral health services and uncovering the challenges they face. The ACAC's analysis is that area behavioral health services provided are fragmented and are not well coordinated with each other or with the medical safety-net providers. As such, there are gaps and overlaps of services, and many of the patients needs identified by behavioral health providers are not being met for lack of availability or coordination of services. Lack of sufficient outpatient psychiatric care and insufficient funding to meet the community demand topped the list of challenges faced by behavioral health service providers. Furthermore, there is no clear understanding of the total community need for each type of behavioral health care service.

MEDICATION ACCESS

Provision of medications to underserved patients with chronic conditions has been shown by a local demonstration project called Project Access at St. John's Health System, to be cost-effective. Several area safety-net clinics offer Prescription Assistance Programs to help patients access medications prescribed to them. These programs are labor-intensive and may divert limited resources away from direct patient care. Having multiple similar programs in several safety-net clinics also results in the duplication of overhead costs for prescription programs incurred by each clinic.

Many medications are also available at a reduced cost within the safety net through the federal 340(b) pharmacy pricing program. Opportunities may exist for maximizing utilization of this resource.

THE ACAC'S ANALYSIS IS THAT AREA BEHAVIORAL HEALTH SERVICES PROVIDED ARE FRAGMENTED AND ARE NOT WELL COORDINATED WITH EACH OTHER OR WITH THE MEDICAL SAFETY-NET PROVIDERS.

SUMMARY OF CONCLUSIONS

UTILIZATION OF SAFETY-NET HEALTH CARE PROVIDERS IS INCREASING IN OUR COMMUNITY. DEMOGRAPHIC AND ECONOMIC TRENDS SUPPORT THE NEED FOR CONTINUED INVESTMENT IN THE SAFETY NET.

HAVING AN ESTABLISHED MEDICAL HOME WITHIN THE SAFETY NET INCREASES UTILIZATION OF PRIMARY CARE, RATHER THAN THE ED, FOR ACUTE CARE NEEDS.

There is adequate physical space in current safety net facilities to increase the number of patient visits. Provider resources could be increased and/or re-distributed to improve patient access, especially for new patients with acute needs.

Opportunities exist to better coordinate patient and information flow to safety net providers, which could increase their efficiency. One example is the provision of medical records when patients are referred into the safety net.

Dental care is essentially unavailable to non-pregnant underserved adults in the safety net due to lack of dental provider resources. Although dental care is available for those with MO HealthNet (Medicaid) dental insurance, extended wait times exist. Therefore, acute dental care is regularly sought in area EDs, which are not equipped to provide definitive treatment.

The local behavioral health system for underserved patients is not well understood, and should be further assessed. Care is poorly coordinated between primary care medical providers and behavioral health providers. Outpatient psychiatric care is largely unavailable to underserved adults.

Opportunities exist for safety-net clinics to coordinate Prescription Assistance Programs to help patients access medications prescribed to them and to promote the effective and safe use of medications. Doing so may demonstrate fiscal responsibility capable of supporting a sustained ability to serve patients in a manner that reduces the incidence of preventable emergency and hospital care.

THE PATIENT

The Patient Voice Task Force of the ACAC has sought to understand the experiences of uninsured and MO HealthNet (Medicaid) patients in obtaining access to health care in Springfield. This goal has been pursued through two primary avenues: (1) a written survey regarding these patients' access to care, conducted from March through May 2010 in area EDs and safety-net clinics, and (2) a series of six focus groups held in May addressing similar issues. This report weaves together the findings of these information gathering efforts in order to provide a data-based platform that might help inform decisions about future directions for The Health Commission and the community.

The survey results presented here are based on 540 completed instruments (324 uninsured and 216 MO HealthNet (Medicaid) patients). The vast majority of the surveys were completed at three sites (33.5% from Ozark Community Hospital ER, 34.8% from the Kitchen Clinic, and 24.8% from Jordan Valley Community Health Center), with very small response rates from St. John's Health System ED (3.9%), CoxHealth South ED (0.7%), and Cox Family Medicine Residency, the Family Medical Care Center (2.2%). No completed surveys were obtained from the CoxHealth North ED.

DEMOGRAPHIC, HEALTH, & INSURANCE STATUS CHARACTERISTICS OF SURVEY RESPONDENTS

The modal descriptive characteristics of survey respondents were as follows: single (45.0%), Caucasian (85.0%), female (69.0%), age 26 to 45 years (48.0%), speak English as primary language (98.0%), high school graduate/ GED attained (32.0%), from a two-person household (25.0%), with household incomes of $0 to $19,999 (77.0%), unemployed (69.0%), and reside in Greene County (81.0%). When asked to assess their overall health on a scale from 1 (very poor health) to 10 (excellent health), some placed themselves in each of these extremes (4% very poor, 5% excellent), but most respondents (59.0%) were in the middle range (i.e., health ratings between 4 and 7).

For those respondents who were employed, only 33% had an employer who offered health insurance. Most worked at jobs where no insurance was offered by the employer (69.0% of uninsured and 64.0% of MO HealthNet). For those who had employers who offer insurance but the respondent did not have coverage, the largest percentage from both groups indicated, "I cannot afford it," as the reason. This was also a consistent theme during the focus groups, as several participants put forth how they would like to have health insurance but their wages were too low to afford the insurance premium offered by their employers. Also of interest to this effort is that those respondents with MO HealthNet (Medicaid) defined themselves as insured, and the majority (60.0%) of the uninsured had not applied for MO HealthNet (Medicaid) in the last six months. It should be noted that most of these patients know that if you are an adult in Missouri you have to be pregnant or disabled to get MO HealthNet (Medicaid). It would not make sense for anyone who did not identify themselves in one of those categories to apply.

FOR THOSE RESPONDENTS WHO WERE EMPLOYED,
ONLY 33% HAD AN EMPLOYER WHO OFFERED HEALTH INSURANCE. MOST WORKED AT JOBS WHERE NO INSURANCE WAS OFFERED BY THE EMPLOYER (69.0% OF UNINSURED AND 64.0% OF MO HEALTHNET).

DIFFICULTY GETTING CARE OUTSIDE OF EMERGENCY ROOMS

While the largest percentage of the uninsured group (37.0%) reported that it was "extremely difficult" to get care outside of the ED when they needed it, the MO HealthNet (Medicaid) respondents reported less difficulty, with 25.0% reporting that getting care outside of the ED was "not difficult at all." During focus groups with uninsured persons, participants consistently spoke of the difficulties in getting a primary care physician when they had no insurance. Most spoke favorably of The Kitchen Clinic and its free medical services to the uninsured. On the other hand, during the MO HealthNet (Medicaid) focus groups, the discussions clearly revealed consistent perceptions of substandard and discriminatory treatment received. Although most in the MO HealthNet (Medicaid) focus groups indicated they had a primary care physician, they also clearly expressed opinions that they were treated differently (received lower quality health care) because of their MO HealthNet (Medicaid) status.

PATTERNS OF CARE AMONG RESPONDENTS

As mentioned previously, the focus groups made it apparent that most MO HealthNet (Medicaid) patients did have a "regular primary care provider," and most uninsured patients did not. The survey results were consistent with this finding as well, in that the majority of uninsured respondents (61.0%) did not have a regular primary care provider, but most MO HealthNet (Medicaid) respondents (74.0%) did. However, the differences between uninsured and MO HealthNet (Medicaid) patients who report having a regular primary care provider are instructive—when asked the last time they'd seen their provider, MO HealthNet (Medicaid) patients were nearly twice as likely to have had a visit within the past six months as were uninsured patients (62.0% compared to 32.0%, respectively). It should be noted that the majority of adults on MO HealthNet (Medicaid) are either pregnant mothers who have frequent prenatal visits or disabled and have multiple chronic conditions which require regular visits. Continuing with this theme, respondents who had not seen their primary care provider in more than a year were asked the reasons for this state of affairs. Although the response rate was small (14.0%), the single most salient barrier cited was "it was too expensive" (6.0%).

UNTREATED HEALTH PROBLEMS

Perhaps not surprisingly, results from the survey indicate that the members of the uninsured group were much more likely than those with MO HealthNet (Medicaid) to have had a health problem that was not treated. That is, of the uninsured, 49.0% reported that in the past year, they had a health problem that was not treated, compared with 29.0% of the MO HealthNet (Medicaid) group. This pattern was certainly reinforced during the focus group discussions, as those with no health insurance revealed coping strategies such as self-medicating when they were ill or reserving part of a prescription and saving it so they would have medication for a future illness.

USE OF ED FOR PROBLEMS THAT COULD BEST BE TREATED IN A PROVIDERS' OFFICE

This is a common occurrence among survey respondents across both groups. However, whereas MO HealthNet (Medicaid) respondents were more likely than the uninsured to have primary care providers, they were also more likely to report going to an ED for a condition that could have been treated by a provider in their office. About half (49.0%) of those with MO HealthNet (Medicaid) reported having gone to an ED for a non-emergency, but substantially fewer of the uninsured (39.0%) said that they had gone to an ED for a problem that could have been treated at a provider's office. Again, focus group discussions reinforced these survey findings, as a number of participants talked about going to the ED as a last resort, but that they preferred to go to a local clinic if it was open and they could get an appointment because ED treatment is so expensive (several discussed their fears of incurring the crushing debt load that can be incurred by one or two visits to the ED).

It is perhaps of interest to note that the distribution of the number of visits to the ED in the past year is actually quite similar among the two respondent groups. Overall, the modal number of ED visits was 2 to 4, with 23.0% of the uninsured and 31.0% of those with MO HealthNet (Medicaid) in this category.

TOP BARRIERS TO GETTING NEEDED HEALTH CARE

This survey item provides perhaps the most direct assessment of the primary question being posed by the ACAC, and the results show a very different pattern of health care barriers between the two respondent groups. Not surprisingly, the number one reason for not getting needed health care among the uninsured is… not having health insurance (reported as such by 77.0%), whereas the single largest response among MO HealthNet (Medicaid) respondents was…not applicable, because they report being able to get the care they need (44.0%). The second most frequent barrier to needed health care was "the cost of care is too expensive" for the uninsured (48.0% mentioned this), and "my insurance does not cover what I need" (11%) for MO HealthNet (Medicaid) respondents. Rounding out the top three for the uninsured was "I cannot afford my insurance co-pay or deductible" (15.0%), whereas the third most frequent barrier for MO HealthNet (Medicaid) patients was not having transportation to the primary care provider (mentioned by 10.0%). There is an obvious incongruity in these results in that 15.0% of uninsured patients mentioned not being able to afford insurance co-pays or deductibles, which would clearly only be of concern if they indeed had insurance. This might best be explained as simple misunderstanding of the questions/answers on this part of the survey—it is perhaps most likely that respondents were actually referring to not being able to afford insurance itself, and not necessarily only the deductibles and co-pays, or that they cannot afford the sliding scale co-pays offered to uninsured patients at some clinics. (Note: The percentages in these findings sum to more than 100.0% because the respondents could provide more than one response.)

DENTAL CARE ACCESS ISSUES

Most respondents (80.0%) reported that they did not have a regular dentist, a figure representing 84.0% of the uninsured group and 75.0% of the MO HealthNet (Medicaid) group. Focus group discussions reinforced this finding. During this process, many complaints were aired reinforcing the theme that dental care for adults is not readily available in the region for those who have no insurance or those with MO HealthNet. Though focus group respondents were grateful for what is available through The Kitchen Clinic and Jordan Valley Community Health Center, the care was decried as very basic and not restorative in nature.

Responses to the question of reasons for not getting needed dental care centered on the cost of dental care and dental insurance issues. For instance, the most often cited reason was "I do not have dental insurance" for the uninsured group (71.0%) and "My insurance does not cover what I need" for the MO HealthNet (Medicaid) group (43.0%). Both groups mentioned the high cost of dental care (51.0% of the uninsured and 30% of those with MO HealthNet (Medicaid)). MO HealthNet (Medicaid) respondents also listed the fact that dentists very often would not accept MO HealthNet (Medicaid), a theme consistently reinforced in the focus groups.

BEHAVIORAL HEALTH CARE ISSUES

Nearly half (48.0%) of the respondents reported no access to behavioral health care (56.0% of the uninsured did not have a counselor or therapist, and 37.0% of MO HealthNet (Medicaid) respondents reported the same). The main reasons for not seeking needed emotional or behavioral health care differed for those with no health insurance and those with MO HealthNet (Medicaid). The majority of MO HealthNet (Medicaid) respondents (58.0%) reported that they can get the care they needed, but a much smaller percentage (22.0%) of the uninsured reported this. Whereas both groups noted the expensive cost of behavioral health care (39.0% of the uninsured and 8% of the MO HealthNet (Medicaid) group), the most frequent barrier to needed behavioral health care listed by the uninsured (60.0%) was "I do not have health insurance."

Regarding need, most respondents (57.0%) reported no behavioral health care problem in the past year for which they needed care. There was little difference in the responses of the two groups. This finding was of some surprise given that poverty is widely recognized as one of the most potent risk factors for the development of behavioral health problems. It is certainly possible that these groups have a different threshold for reporting issues as "behavioral health problems," or that "behavioral health" is a relatively low priority in the midst of an ongoing struggle to take care of subsistence-level needs.

While the majority of respondents (64.0%) did not need behavioral health care (or did not respond to the question), those who did were most likely to report going to a clinic to see a therapist or counselor. For instance, a number of uninsured mentioned The Kitchen Clinic. Respondents from both groups occasionally listed Burrell Behavioral Health or the Forest Institute as their go-to behavioral health resource. During the focus group discussions, several participants mentioned their belief that there is a lack of qualified mental health professionals in the Greene County area, as well as affordable psychiatric care. Several of them had received counseling services from student interns at places such as the Forest Institute.

Turning to substance abuse issues, the vast majority of respondents (89.5%) indicated no drug or alcohol problems in the past year, with no significant differences between the groups in these assertions. Although only a small number of respondents in this study reported having a drug or alcohol problem, those who did were most likely to indicate that they went to a clinic for treatment (3.5%). Again, the uninsured tended to list the Kitchen Clinic, one person mentioned the Carol Jones Treatment Center, and another listed the Marian Center.

CONCLUSIONS AND IMPLICATIONS

Potential concerns raised by, or implications of, these findings that may be worthy of follow up, further analysis, and action planning are:

60.0% of the uninsured surveyed had not applied for MO HealthNet (Medicaid) in the last six months, and yet 49.0% of them had gone without treatment for a problem condition. Later in the survey, and in focus groups, we learn that MO HealthNet (Medicaid) recipients are more likely to have a "regular primary care provider" and tend to be able to get care when they need it, though fewer seem to get dental and behavioral health help. Perhaps these data suggest a need to step up efforts to have patients apply and re-apply for MO HealthNet (Medicaid) if they are eligible. Clearly, some clinics and providers do this as a matter of course when accepting patients and broadening this practice could help solve some of the identified problems of the uninsured.

The vast majority of respondents were not insured, despite being employed.

The large proportion of MO HealthNet (Medicaid) respondents who have seen their physician in the last six months (62.0%) possibly reflects greater levels of illness, or better access for preventive care than is widely assumed.

There were relatively low levels of reported behavioral health problems among populations known to have tremendously high levels of risk factors. Respondents stated confusion or lack of knowledge about where to go for appropriate care of behavioral health problems.

Comments from MO HealthNet (Medicaid) focus group participants about feeling like they were treated differently (more poorly) are also of interest, particularly in light of the historically high no-show rates for MO HealthNet (Medicaid) members, which may represent acculturation differences. However, if we take these findings at face value and conclude that this perceived lack of respect does indeed pervade our health care services, what can be done to remedy this thorny problem?

It is also of interest that, at least among those surveyed, uninsured and MO HealthNet (Medicaid) patients are perhaps not as likely to visit the ED as the general public might think. Yet, those covered by MO HealthNet (Medicaid), knowing the government is funding most of the bill, are more likely than uninsured patients to go to the ED for a non-emergent problem that could best be treated by a provider in their office.

Do MO HealthNet patients think of MO HealthNet (Medicaid) as "insurance," as many of the responses would suggest they do? What are the implications of this for policymakers and for treatment providers?

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Dental Director
Jordan Valley Community Health Center Dental Clinic

Janie Vestal, MD
Co-Medical Director
The Kitchen Clinic

SUMMARY OF PROVIDER ORGANIZATIONS

COXHEALTH

CoxHealth, located in Springfield, Missouri is a community-owned private, not-for-profit organization that provides comprehensive care for the residents of approximately 22 counties with two hospitals and 770 beds in southwest Missouri and northwest Arkansas. CoxHealth's mission is, "To improve the health of the communities we serve through quality health care, education, and research." Founded in 1906, CoxHealth has focused on the community's health through a culture of innovation and engagement and has been awarded as a "Top 100 Integrated Health System" for their service.

FAMILY MEDICAL CARE CENTER

The Family Medical Care Center is an outpatient clinic that functions as part of the Family Medicine Residency Program under CoxHealth. This practice encompasses outpatient and inpatient management of health maintenance, diseases, disorders and complications of all body systems with a focus on family practice. The clinic is open to new patients, regardless of payer. Current payer mix is 44.0% Medicaid, 33.0% Commercial Insurance, 15.0% Medicare and 8.0% Self-Pay. Payment plans and financial assistance is available through the hospital. The clinic is open Monday through Friday from 8:00 a.m. to 5:00 p.m.

JORDAN VALLEY COMMUNITY HEALTH CENTER

Advocates for a Healthy Community, (Doing Business As) Jordan Valley Community Health Center is a 330-funded Community Health Center. Established in 2002 to serve as a health care safety-net to the medically underserved in Greene, Webster and Dallas counties in southwest Missouri, Jordan Valley Community Health Center is the sole Federally Qualified Health Center in Springfield. Jordan Valley Community Health Center offers primary medical, dental and behavioral health services to over 30,000 patients annually. Jordan Valley is open to new patients, regardless of payer. Current payer mix is 30.6% Self-Pay, 43.5% Medicaid, 10.0% Medicare and 15.9% Commercial Insurance. The clinic in Springfield is open from 8:00 a.m. to 9:00 p.m. Monday through Friday and 8:00 a.m. to 5:00 p.m. Saturday.

OZARKS COMMUNITY HOSPITAL

Ozarks Community Hospital (formerly known as Doctors Hospital) is a community-focused, for-profit health system. Ozarks Community Hospital's mission is, "[To be] dedicated to providing exceptional health care and preventive services to our patients in an atmosphere of compassion, respect, and dignity, with a commitment to care for the underserved and to improve access to care." Ozarks Community Hospital is unique because more than 80.0% of OCH's patients have governmental insurance or are self pay; OCH has never sued a patient to collect a bill; OCH has never reported a patient to a credit bureau for nonpayment; OCH provides discounts of 40.0% or more to uninsured patients; OCH has a written policy that says we can fire employees simply if they are not nice to other people; OCH has reopened two closed hospitals and kept them open; OCH receives no public or private support and pays all local, state and federal taxes; and OCH is the lowest cost health care system in the nation based on hospital and physician utilization by Medicare beneficiaries.

ST. JOHN'S HEALTH SYSTEM

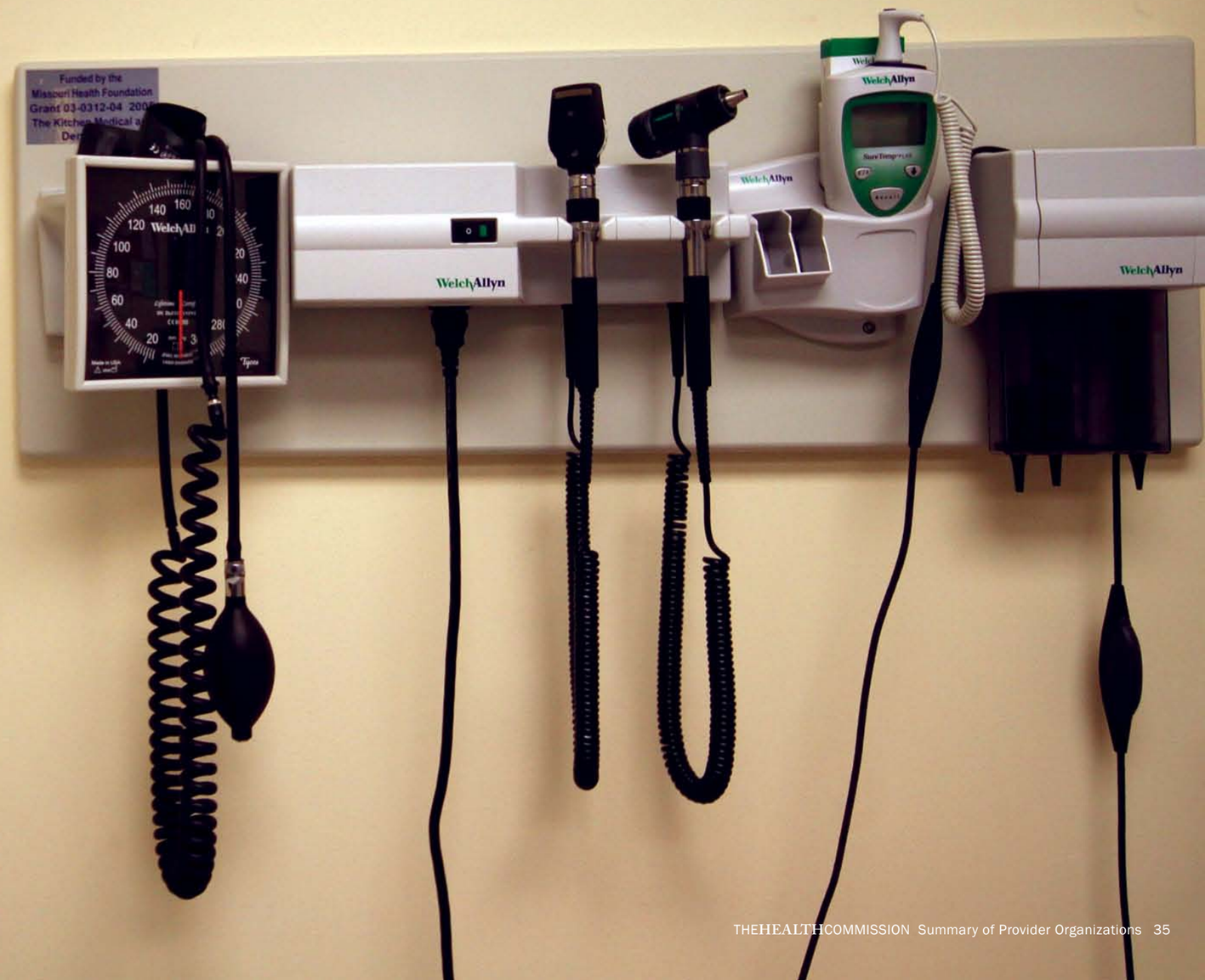
St. John's Health system is a not-for-profit organization and is part of Mercy based in St. Louis. St. John's Health System provides service to a 35 county area with 5 hospitals and 1,016 patient beds in southeastern Missouri and northern Arkansas. The mission of St. John's Health System is, "As the Sisters of Mercy before us, we bring to life the healing ministry of Jesus through our compassionate care and exceptional service." Founded in 1891 by three Sisters of Mercy, St. John's Health System has grown to be one of the nation's "Top Three Integrated Health Systems" for their dedication to providing care to patients in new, innovative and integrated ways.

THE KITCHEN CLINIC

The Kitchen Clinic is a ministry of The Kitchen, Inc., a 501(c)(3) nonprofit corporation. The mission of this free clinic is, "To offer health care and hope to uninsured, low-income individuals and families with dignity and compassion." The clinic has an Advisory Committee which reports to the Board of Trustees of The Kitchen, Inc. The clinic is funded through grants and private donors. In-kind donors include CoxHealth, St. John's Health System, Ozarks Community Hospital and extensive volunteerism. The services provided include primary care and medications, counseling and health education and limited specialty care by volunteers. Educational partners include AHEC, Drury University, Everest College, The Forest Institute, Missouri State University, St. John's/Southwest Baptist University School of Nursing, and Vatterott College. The clinic hours are 8:00 a.m. to 5:00 p.m. Monday, Tuesday and Wednesday; 8:00 a.m. to 8:00 p.m. Thursday; and 8:00 a.m. to 12:00 p.m. Friday.

SPRINGFIELD-GREENE COUNTY HEALTH DEPARTMENT

In 1873, the City of Springfield established the Department of Health. Today, with a budget of nearly $10 million and a staff of 110, the Health Department serves a city and county combined population of approximately 267,000 people. The department is organized into five divisions: Administration, which is responsible to oversee all critical functions of the department and is responsible to handle political dealings with City Council, the Mayor and City Manager. Public health administrators are responsible for policy development and fiscal responsibility. Environmental Services, which includes the Milk Control Program, the Food, Daycare, and Lead Program, the Environmental Compliance office, Animal Control, and Air Quality Control. Community Health and Epidemiology, which focuses on disease surveillance and the management and prevention of disease. Maternal/Child and Family Health, which includes the Women, Infants and Children (WIC) program, immunizations, childcare providers services and an outpatient clinic. Planning, which prepares emergency response plans, pandemic influenza plans, and is in charge of the Emergency Response Team.



DEFINITIONS

ACCESS: According to Webster's Medical Dictionary, access is the ability for a person to receive (access) medical, dental, behavioral or specialty health care services, which is a function of (a) availability of health care personnel and supplies and (b) the ability to pay for those services.

ACUTE CARE: According to Webster's Medical Dictionary, acute care is treatment of a severe medical condition that is of short duration and at a crisis level. Many hospitals are acute care facilities with the goal of discharging the patient as soon as the patient is deemed healthy and stable, with appropriate discharge instructions. The term is generally associated with care rendered in an Emergency Department (ED), ambulatory care clinic, or other short-term stay facility.

ADULT: As defined by the American Academy of Family Physicians (AAFP) and the Access to Care Advisory Committee (ACAC), adult patients are ages 19 and older.

APPROPRIATE ED ACCESS: As defined by Mark Murray (2007), appropriate ED access occurs with conditions that are acute in onset or severe in nature such as trauma, abrupt onset illness a patient has never experienced before, an acute complication of a chronic condition, etc.

BEHAVIORAL HEALTH: According to Webster's Medical Dictionary, behavioral health is either a level of cognitive or emotional well-being or an absence of a mental disorder.

CHRONIC CARE: According to Webster's Medical Dictionary, chronic care addresses preexisting or long term illness that over time can cause changes in the body, as opposed to acute care which is concerned with new short-term or severe illness of brief duration.

DENTAL HEALTH: As defined by the American Dental Association, dental health is the condition of the dentition (teeth) and its supporting tissue (gums), that are free of decay, pathology, and discomfort. It includes regular preventative behaviors (regular home care and dental visits) to maintain the healthy condition.

EMERGENCY DEPARTMENT (ED): According to Webster's Medical Dictionary, this department of a hospital responsible for the provision of medical and surgical care to patients arriving at the hospital in need of immediate care. The ED is also referred to as the Emergency Room or ER.

FEDERAL POVERTY LEVEL (FPL): As defined by the United States Department of Health and Human Services, the Federal Poverty Level is the federal poverty line or income thresholds determined by the United States Department of Health and Human Services; used as a measure to determine if a person or family is eligible for assistance through various federal programs such as Medicaid. In 2009, for a family of 4, this was set at $22,050.00.

FEDERALLY QUALIFIED HEALTH CENTER (FQHC): Public and private non-profit health care organizations that meet certain criteria under the Medicare and Medicaid Programs (respectively, Sections 1861(aa)(4) and 1905(l)(2)(B) of the Social Security Act and receive funds under the Health Center Program (Section 330 of the Public Health Service Act). Community Health Centers serve a variety of underserved populations and areas. Community Health Centers are community-based and patient-directed organizations that serve populations with limited access to health care. These include low income populations, the uninsured, those with limited English proficiency, migrant and seasonal farm workers, individuals and families experiencing homelessness, and those living in public housing. US Dept HHS.

HEALTH DISPARITY: As defined by the Robert Wood Johnson Foundation, health disparities are gaps in the quality of health and health care across racial, ethnic, sexual orientation and socioeconomic groups. The Health Resources and Services Administration defines health disparities as population-specific differences in the presence of disease, health outcomes, or access to health care.

HEALTH OUTCOME: As defined by the Robert Wood Johnson Foundation, health outcomes are changes in the health status of an individual, group or population which is attributable to a planned intervention or series of interventions, regardless of whether such an intervention was intended to change health status.

INAPPROPRIATE ED ACCESS: As defined by Mark Murray, inappropriate ED access is for the treatment of self-limited acute minor conditions or chronic stable conditions, more suitable for treatment in less resource intense environments outside the ED.

MEDICAL HEALTH: According to Webster's Medical Dictionary, medical health is a condition of physical, mental, and social well-being and the absence of disease or other abnormal condition.

MO HEALTHNET (MEDICAID): As defined by the Missouri Department of Social Services and Division of MO HealthNet, this is Missouri's Medicaid program. Patients eligible for this program are pregnant, have young children, low-income, disabled or elderly. Patients and their family may be eligible for Medicaid depending their age, immigration status, income, resources, and health condition. Patients receiving cash assistance from the Family Support Division, including Temporary Assistance may be eligible for a Medicaid card. Patients may also be eligible if they are at least 65 years old, blind, disabled, receiving Social Security disability or SSI benefits, pregnant, or have limited income.

ORAL HEALTH: As defined by the American Dental Association, oral health is the state of being free of chronic oral-facial pain conditions, oral and pharyngeal (throat) cancers, oral soft tissue lesions, birth defects such as cleft lip and palate, and scores of other diseases and disorders that affect the oral, dental, and craniofacial tissues, collectively known as the craniofacial complex.

PATIENT-CENTERED MEDICAL HOME: According to the National Committee for Quality Assurance, a patient-centered medical home is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family. Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner. NCQA.

PEDIATRIC: As defined by the American Academy of Family Physicians (AAFP)and the ACAC, pediatrics are residents between the ages of infancy and 18 years old.

PRIMARY CARE PROVIDER: As defined by the American Academy of Family Physicians (AAFP), a primary care provider is a physician or clinician chosen by or assigned to a patient, who both provides primary care and acts as a gatekeeper to control access to other medical services.

SAFETY NET: As defined by the Institute of Medicine (IOM), the safety net is comprised of providers that organize and deliver a significant level of health care and other health-related services to uninsured, Medicaid, and other vulnerable patients. These providers have two distinguishing characteristics: (a) by legal mandate or explicitly adopted mission they maintain an "open door," offering access to services to patients regardless of their ability to pay; and (b) a substantial share of their patient mix is uninsured, Medicaid, and other vulnerable patients.

SOCIAL DETERMINANTS OF HEALTH: As defined by the World Health Organization (WHO), the social determinants of health are conditions in which people are born, grow, live, work and age, including the ability to access food, clothing, shelter, environmental safety, education and health care. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices. The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between populations. .

UNDERSERVED: As defined by the ACAC, the underserved are those who are uninsured or have MO HealthNet (Medicaid) insurance.

UNDUPLICATED PATIENT: As defined by the ACAC, an unduplicated patient is one in a health care setting who is counted only one time in a year, even if the patient had multiple visits.

UNINSURED: As defined by the ACAC, the uninsured are individuals that do not have any form of health care insurance and must pay out of pocket for all health care services.

FMCC: Family Medical Care Center.

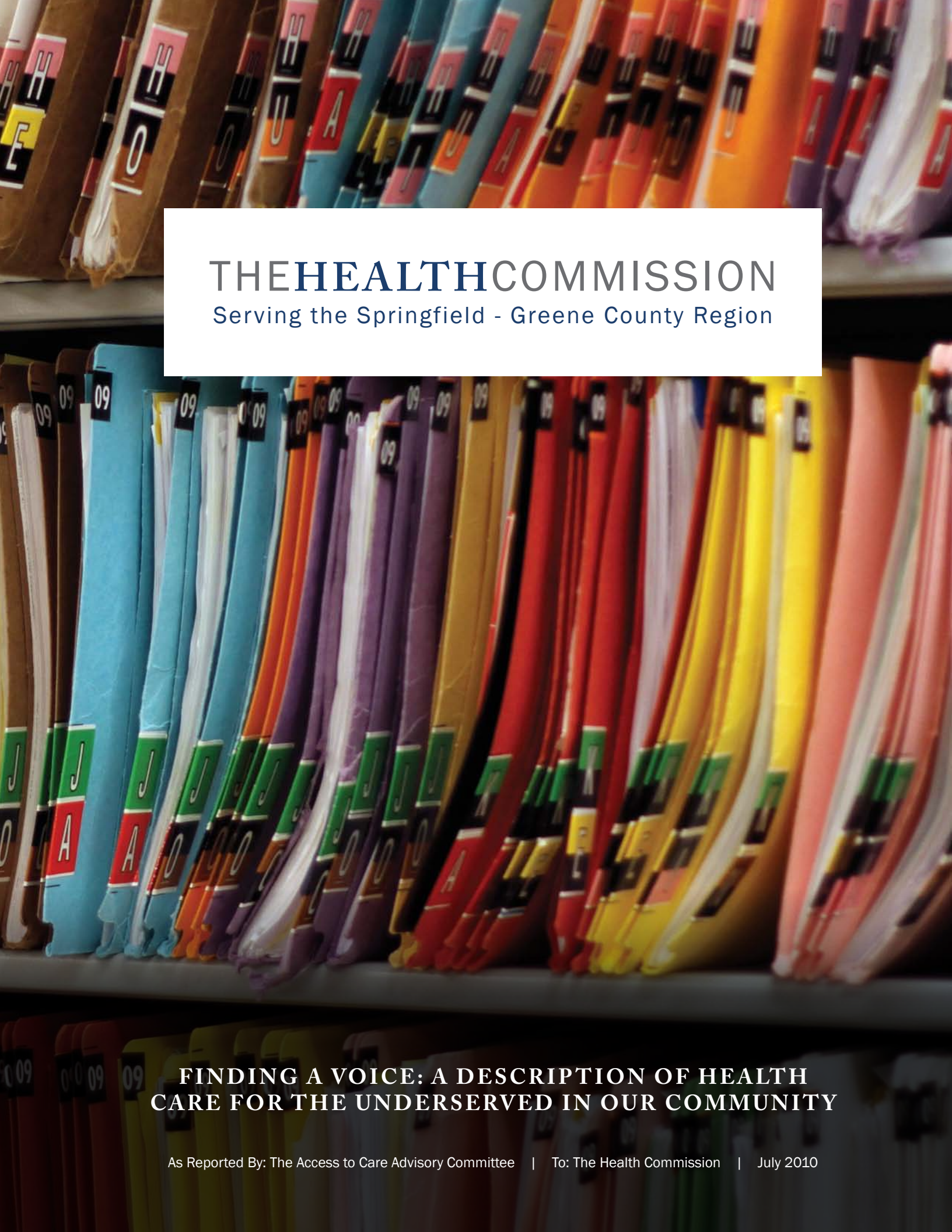
IHI: Institute for Healthcare Improvement.

JVCHC: Jordan Valley Community Health Center (local FQHC).

KC: The Kitchen Clinic.

OCH: Ozarks Community Hospital (formerly known as Doctor's Hospital)

PCP: Primary Care Physician



THE HEALTH COMMISSION

Serving the Springfield - Greene County Region

FINDING A VOICE: A DESCRIPTION OF HEALTH CARE FOR THE UNDERSERVED IN OUR COMMUNITY

As Reported By: The Access to Care Advisory Committee | To: The Health Commission | July 2010